FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0023945

Facility Name: ALDEN HEATHER REHAB & HCC

Address: 15600 S HONORE (Number) HARVEY (City) 60426 (Zip Code)

County:

Telephone Number: (708)333-9550 **Fax #** (708)333-9554

IDPA ID Number: 36-2949011

Date of Initial License for Current Owners: 06/01/81

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: STEVEN M KROLL **Telephone Number:** (773)286-6622

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed) _____ (Date)
	(Type or Print Name) STEVEN M KROLL
	(Title) CHIEF FINANCIAL OFFICER
Paid Preparer	(Signed) _____ (Date)
	(Print Name and Title)
	(Firm Name & Address)
	(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number ALDEN HEATHER REHAB & HCC # 0023945 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	172	Skilled (SNF)	172	62,952	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	172	TOTALS	172	62,952	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,266	503	1,236	8,005	8
9	SNF/PED					9
10	ICF	24,732	446	117	25,295	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,998	949	1,353	33,300	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.90%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/78

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 9 and days of care provided 788

Medicare Intermediary ADMINISTAR FEDERAL INC

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ALDEN HEATHER REHAB & HCC # 0023945 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	182,506	28,984		211,490	1,000	212,490		212,490			1
2	Food Purchase		237,560		237,560	(30,769)	206,791	(23,838)	182,953			2
3	Housekeeping	132,824	17,440		150,264	2,854	153,118		153,118			3
4	Laundry	68,165	18,186		86,351	429	86,780		86,780			4
5	Heat and Other Utilities			100,186	100,186		100,186		100,186			5
6	Maintenance	38,068		145,739	183,807	1,513	185,320	1,562	186,882			6
7	Other (specify):*											7
8	**TOTAL General Services**	421,563	302,170	245,925	969,658	(24,973)	944,685	(22,276)	922,409			8
	B. Health Care and Programs											
9	Medical Director			15,600	15,600		15,600		15,600			9
10	Nursing and Medical Records	1,213,421	53,971	7,428	1,274,820	7,268	1,282,088	(420)	1,281,668			10
10a	Therapy			555	555		555		555			10a
11	Activities	70,219	3,577	2,009	75,805	456	76,261		76,261			11
12	Social Services	42,918		811	43,729		43,729		43,729			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,326,558	57,548	26,403	1,410,509	7,724	1,418,233	(420)	1,417,813			16
	C. General Administration											
17	Administrative	83,348			83,348		83,348		83,348			17
18	Directors Fees											18
19	Professional Services			637,904	637,904	(36,251)	601,653	(544,511)	57,143			19
20	Dues, Fees, Subscriptions & Promotions			28,126	28,126	(1,063)	27,063	(16,539)	10,524			20
21	Clerical & General Office Expenses	341,343	17,584	22,618	381,545	149	381,694	37,608	419,302			21
22	Employee Benefits & Payroll Taxes			318,365	318,365	18,163	336,528	37,839	374,367			22
23	Inservice Training & Education											23
24	Travel and Seminar			887	887		887	8,769	9,656			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			46,348	46,348		46,348	93	46,441			26
27	Other (specify):*			18,000	18,000		18,000	(18,000)				27
28	**TOTAL General Administration**	424,691	17,584	1,072,248	1,514,523	(19,002)	1,495,521	(494,741)	1,000,781			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,172,812	377,302	1,344,576	3,894,690	(36,251)	3,858,439	(517,436)	3,341,003			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ALDEN HEATHER REHAB & HCC #0023945 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			54,634	54,634		54,634	98,725	153,359			30
31	Amortization of Pre-Op. & Org.							586	586			31
32	Interest			63,833	63,833		63,833	164,601	228,434			32
33	Real Estate Taxes			306,540	306,540	36,251	342,791	3,801	346,592			33
34	Rent-Facility & Grounds			519,755	519,755		519,755	(519,755)				34
35	Rent-Equipment & Vehicles			10,416	10,416		10,416	12,021	22,437			35
36	Other (specify):* MIP insur.							10,183	10,183			36
37	TOTAL Ownership			955,178	955,178	36,251	991,429	(229,838)	761,591			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		67,637	105,413	173,050		173,050	(9,819)	163,231			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			94,977	94,977		94,977		94,977			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		67,637	200,390	268,027		268,027	(9,819)	258,208			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,172,812	444,939	2,500,144	5,117,895		5,117,895	(757,092)	4,360,803			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ALDEN HEATHER REHAB & HCC # 0023945 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	83,095	30		9
10	Interest and Other Investment Income	(35)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(230)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,875)	32		18
19	Entertainment				19
20	Contributions	(2,372)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,000)	27		24
25	Fund Raising, Advertising and Promotional	(9,736)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(5,171)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 41,676		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(451,167)		34
35	Other- Attach Schedule	(347,601)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (798,768)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (757,092)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

ALDEN HEATHER REHAB & HCC

ID# 0023945

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	non-cost part b c/a in page 4 costs	$ (150)	39	1
2	non-cost: hmo nurs.supply c/a(gl 5026)non-allow.	(2,005)	39	2
3	non-cost: hmo pharmacy c/a(gl 5042)non-allow.	(3,706)	39	3
4	non-cost: hmo therapy c/a(gl5040)non-allow.	(4,298)	39	4
5	deferred maint. Exp on painting>$1,500('99purch)	3,702	6	5
6	deferred maint. Exp on painting>$1,500('00purch)	1,505	6	6
7	painting exp>$1,500 for 2000 purchases	(9,031)	6	7
8	eliminate rent paid due to sale/leaseback	(519,755)	34	8
9	Mortgage interest(see amortiz. Schedule, also to pg 9)	166,467	32	9
10	MIP Insurance(see amort.schedule)	10,183	36	10
11	adj. Deprec exp. For yr 2000 actual	315	30	11
12	Record IDPH license fee for 2000(not accrued)	400	20	12
13	back out exp adj for prior year blood gluc consult	8,771	19	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
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85				85
86				86
87				87
88				88
89				89
90	**Total**	(347,601)		90

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number ALDEN HEATHER REHAB & HCC **#** 0023945 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(230)	0	0	(23,608)	0	0	0	0	0	0	0	(23,838)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(3,824)	0	5,386	0	0	0	0	0	0	0	0	1,562	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,054)	0	5,386	(23,608)	0	0	0	0	0	0	0	(22,276)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	(420)	0	0	0	0	0	0	(420)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	(420)	0	0	0	0	0	0	(420)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	8,771	0	(553,140)	0	0	0	0	(141)	0	0	0	(544,511)	19
20	Fees, Subscriptions & Promotions	(16,879)	0	340	0	0	0	0	0	0	0	0	(16,539)	20
21	Clerical & General Office Expenses	0	0	22,734	11,604	3,270	0	0	0	0	0	0	37,608	21
22	Employee Benefits & Payroll Taxes	0	0	38,694	0	(855)	0	0	0	0	0	0	37,839	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	8,769	0	0	0	0	0	0	0	0	8,769	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	93	0	0	0	0	0	0	0	0	93	26
27	Other (specify):*	(18,000)	0	0	0	0	0	0	0	0	0	0	(18,000)	27
28	**TOTAL General Administration**	(26,109)	0	(482,510)	11,604	2,415	0	0	(141)	0	0	0	(494,741)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(30,162)	0	(477,124)	(12,004)	1,995	0	0	(141)	0	0	0	(517,436)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ALDEN HEATHER REHAB & HCC # 0023945 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	83,410	0	15,315	0	0	0	0	0	0	0	0	98,725	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	586	0	0	0	0	586	31
32	Interest	160,557	0	3,074	0	0	0	970	0	0	0	0	164,601	32
33	Real Estate Taxes	0	0	3,801	0	0	0	0	0	0	0	0	3,801	33
34	Rent-Facility & Grounds	(519,755)	0	0	0	0	0	0	0	0	0	0	(519,755)	34
35	Rent-Equipment & Vehicles	0	0	12,021	0	0	0	0	0	0	0	0	12,021	35
36	Other (specify):*	10,183	0	0	0	0	0	0	0	0	0	0	10,183	36
37	**TOTAL Ownership**	(265,605)	0	34,211	0	0	0	1,556	0	0	0	0	(229,838)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(10,159)	0	0	(8,426)	(10,537)	0	19,303	0	0	0	0	(9,819)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(10,159)	0	0	(8,426)	(10,537)	0	19,303	0	0	0	0	(9,819)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(305,925)	0	(442,913)	(20,430)	(8,542)	0	20,859	(141)	0	0	0	(757,092)	45

Facility Name & ID Number ALDEN HEATHER REHAB & HCC # 0023945 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Alden Management Services, Inc.	100	see pg 6k…		see pg 6k…		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$	Alden Management Services, Inc.	100.00%	$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ALDEN HEATHER REHAB & HCC # 0023945 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	maintenance/utilities	$	Alden Management Services, Inc.	100.00%	$ 5,386	$ 5,386	15
16	V	19	professional fees	560,520	Alden Management Services, Inc.		7,380	(553,140)	16
17	V	20	licenses/fees		Alden Management Services, Inc.		340	340	17
18	V	21	gen'l & admin		Alden Management Services, Inc.		22,734	22,734	18
19	V	22	employee costs		Alden Management Services, Inc.		38,694	38,694	19
20	V	24	auto/seminar		Alden Management Services, Inc.		8,769	8,769	20
21	V	26	insurance		Alden Management Services, Inc.		93	93	21
22	V	30	depreciation		Alden Management Services, Inc.		15,315	15,315	22
23	V	32	interest		Alden Management Services, Inc.		3,074	3,074	23
24	V	33	real estate tax		Alden Management Services, Inc.		3,801	3,801	24
25	V	35	auto lease		Alden Management Services, Inc.		12,021	12,021	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 560,520			$ 117,607	$ * (442,913)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN HEATHER REHAB & HCC # 0023945 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		2	tube feeding	$ 38,458	Pyramid Healthcare Services	0.00%	$ 14,850	$ (23,608)	15
16	V		39	nursing supplies	7,508	Pyramid Healthcare Services		3,079	(4,429)	16
17	V		39	supplies/per diem fees	11,104	Pyramid Healthcare Services		7,107	(3,997)	17
18	V		21	gen'l & admin.		Pyramid Healthcare Services		11,604	11,604	18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 57,070			$ 36,640	$ * (20,430)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN HEATHER REHAB & HCC # 0023945 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	drugs	$ 26,921	Forum Extended Care II, Inc.	0.00%	$ 20,264	$ (6,657)	15
16	V	10	house stock	1,699	Forum Extended Care II, Inc.		1,279	(420)	16
17	V	39	iv	15,692	Forum Extended Care II, Inc.		11,812	(3,880)	17
18	V	22	empl vaccin	3,456	Forum Extended Care II, Inc.		2,601	(855)	18
19	V	21	gen'l & admin.		Forum Extended Care II, Inc.		3,270	3,270	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 47,768			$ 39,226	$ * (8,542)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN HEATHER REHAB & HCC # 0023945 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	THERAPY	$ 83,779	COMMUNITY PHYSICAL THERAPY	100.00%	$ 103,082	$ 19,303	15
16	V	31	AMORTIZATION		COMMUNITY PHYSICAL THERAPY		586	586	16
17	V	32	INTEREST		COMMUNITY PHYSICAL THERAPY		970	970	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 83,779			$ 104,638	$ * 20,859	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN HEATHER REHAB & HCC # 0023945 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		19	construction management fees	$ 10,028	ALDEN BENNETT CONSTRUCTION	0.00%	$ 9,887	$ (141)	15
16	V		19	designing fees	1,207	Alden Design Group	0.00%	1,207		16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 11,235			$ 11,094	$ * (141)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN HEATHER REHAB & HCC # 0023945 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg	President-AMS	CEO	100.00	187,770	1.372	3.43	SALARY	$ 6,676	21-1	1
2	Lauren Magnusson	Clinical Coordin.	nursing review	a.	71,933	1.372	3.43	SALARY	2,558	21-1	2
3	Terry Magnusson	Administrator/other	admin/mainten.	b.	72,567	1.372	3.43	SALARY	1,053	21-1	3
4	Audra Schlossberg-Elisco	Massage Therapist	massage therapy	c.	6,851	0	0.00	feee	6,851	10a-3	4
5											5
6											6
7											7
8											8
9											9
10	a. Lauren is the daughter of Floyd Schlossberg and worked as a clinical coordinator for Alden Management Services in 2000.										10
11	b. Terry is the son-in-law of Floyd Schlossberg.He was the administrator of Alden Valley Ridge for 7 months and in construction/misc. for 5 months in 2000.										11
12	c. Daughter of Floyd Schlossberg. Audra worked as a massage therapist for the year at various Alden facilities.										12
13								TOTAL	$ 17,138		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number ALDEN HEATHER REHAB & HCC # 0023945 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		see page 8a…				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ALDEN HEATHER REHAB & HCC # 0023945 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Proforma allocation of						$	$			$	1
2	mortgage interest due to											2
3	sale/leaseback		x	Mortgage Construction	$17,353.57	6/1/80	2,430,000	1,994,872	2/1/20	8.2500	166,467	3
4												4
5												5
	Working Capital											
6	CPT INTEREST	X		WORKING CAPITAL	NONE					VARIES	970	6
7	line of cr interest		x	WORKING CAPITAL	NONE					VARIES	57,959	7
8	related party-interest		x	WORKING CAPITAL	NONE					VARIES	3,074	8
9	TOTAL Facility Related				$17,353.57		$ 2,430,000	$ 1,994,872			$ 228,470	9
	B. Non-Facility Related*											
10	HM-INTEREST INCOME		X	offset interest expense with interest income							(35)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (35)	14
15	TOTALS (line 9+line14)						$ 2,430,000	$ 1,994,872			$ 228,434	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ALDEN HEATHER REHAB & HCC # 0023945 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	444,067	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	366,150	2
3. Under or (over) accrual (line 2 minus line 1).	$	(77,917)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	384,457	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	36,251	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	342,791	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	329,941	8
	1996	393,366	9
	1997	384,874	10
	1998	422,921	11
	1999	366,150	12

LINE 4: 2000 ACCRUAL BASED ON 5% INCREASE OF PRIOR YEAR BILL: $366,150 X 1.05 = 384,458

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number ALDEN HEATHER REHAB & HCC # 0023945 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 48,971 B. General Construction Type: Exterior BRICK/CONCRETE Frame STEEL Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	PATIENT CARE	62,115	1978	$ 90,580	1
2					2
3	TOTALS	62,115		$ 90,580	3

Facility Name & ID Number ALDEN HEATHER REHAB & HCC # 0023945 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	49		1978	1975	$ 496,626	$	27	$ 18,394	$ 18,394	$ 400,372	4
5	123		1980	1980	1,789,311		30	59,644	59,644	1,264,266	5
6	addition		1979	1979	38,500		30	1,283	1,283	26,525	6
7											7
8											8
	Improvement Type**										
9	LAND IMPROVEMENT/ROOFING/HVAC/MISC.			1980	168,496		10-27	3,279	3,279	148,633	9
10	PAVING/PAINTING/DRAINAGE TILE/CABINETS			1981	13,153		10-30	495	495	10,737	10
11	ROOFING			1983	3,100		12			3,100	11
12	DOOR WINDOW/BEARING ASSEMBLY/WATER PUMP -A/C			1984	15,805		5			15,805	12
13	ROOFING/HEAT EXCHANGE/MOTOR/BASEBOARD			1985	17,603		8-10			17,603	13
14	ROOF REPAIR/SEAL PARKING LOT/HEAT EXCHANGE/MISC			1986	40,170		2-10			40,170	14
15	COMPRESSOR REPR/INSTLL FLOW SWTCH/REWIRE ALARM			1988	15,385		5 & 10			15,385	15
16	REPL HEAT EXCHANGE/ROOFTOP EXHST/RE-BRICK WALL			1991	22,663	486	5-25	486	(0)	17,176	16
17	HOT WATER TANK/SEWER REPAIR			1992	15,092	533	5 & 15	533		11,735	17
18	SEWAGE EJECTOR/VALVE/MOTOR			1993	12,871	1,038	5 & 10	1,038		9,973	18
19	ROOF REPAIR/BOILER/PUMP REPAIR/ALARM REPAIR			1994	32,136		3			32,136	19
20	ALARM REPAIR/LOCK SET & KEYS/FLOOR REPAIR			1995	43,408	1,840	3-20	1,840		32,537	20
21	TILE INSTALLED & REPAIR CORRIDOR			1996	1,558	156	10	156		753	21
22	REMOVED & REPLACED NEW MOTOR			1996	3,292	329	10	329		1,591	22
23	REMOVED & INSTALLED NEW MOTOR			1996	1,714	171	10	171		828	23
24	ELECTRICAL REPAIR			1996	3,127	156	20	156		730	24
25	WINDOW REPAIR			1996	6,466	323	20	323		1,482	25
26	VALVE REPAIR			1996	1,523	102	15	102		465	26
27	BOILER LEAKING			1996	6,876	458	15	458		1,948	27
28	WINDOW REPAIR			1996	2,713	136	20	136		554	28
29	WINDOW REPAIR			1993	7,441		5			7,441	29
30	WINDOW REPAIR			1994	13,715		5			13,715	30
31	FLOOR TILE & BASE			1995	788	39	20	39		220	31
32	INSTALL ASPHALT			1996	16,215	1,622	10	1,622		7,162	32
33	INSTALL DOOR FRAME			1997	2,517	252	10	252		923	33
34	INSTALL VENT PIPE FOR DRYER			1997	6,180	1,236	5	1,236		4,944	34
35	INSTALL TILE			1997	1,706	341	5	341		1,365	35
36	TOTAL (lines 4 thru 35)				$ 2,800,150	$ 9,218		$ 92,313	$ 83,095	$ 2,090,274	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALDEN HEATHER REHAB & HCC # 0023945 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	REPLACE BOILER ROOM - TOP A/C			1997	6,000	1,200	5	1,200		4,200	9
10	INSTALL GAS PIPE			1997	4,220	844	5	844		3,376	10
11	INSTALL NEW VALVE AND RECOPPER			1998	1,864	373	5	373		1,087	11
12	PIPING			1998	7,104	284	25	284		805	12
13	ROOF REPAIR			1998	2,920	292	10	292		827	13
14	REPAIR & CHECK VOLTAGE OUTPUT			1998	1,780	356	5	356		1,009	14
15	REPLACED VALVE - HOT WATER			1998	3,270	654	5	654		1,798	15
16	REMODELED & DECORATED ROOMS			1998	28,760	1,917	15	1,917		5,113	16
17	WHIRLPOOL TURBINE			1998	1,599	320	5	320		853	17
18	REPLACE EXHAUST FAN			1998	1,950	130	15	130		347	18
19	FIX FLOOR TILE			1998	3,626	363	10	363		997	19
20	INSTALL DOOR MONITORING SYSTEM			1998	1,587	159	10	159		384	20
21	INSTALL SECURITRON ANNUNCIATOR			1998	1,764	176	10	176		426	21
22	REPLACE BOILER ON STEAMER			1998	4,283	428	10	428		1,106	22
23	INSTALL RESET CONTROL ON BOILER			1998	3,900	195	20	195		471	23
24	WRAP CHILLER PIPES			1998	2,682	134	20	134		291	24
25	REPLACE PUMP MOTOR			1998	4,425	295	15	295		639	25
26	PAINT			1998	7,845	1,569	5	1,569		4,315	26
27	Climate Service (cleaned boiler, replace valve)			1999	1,374	69	20	69		137	27
28	Climate Service (replace mixing valve, thermostat)			1999	3,317	221	15	221		442	28
29	Climate Service (install hot water heater)			1999	7,391	493	15	493		944	29
30	Climate Service (install roof top replacement)			1999	9,935	994	10	994		1,904	30
31	Climate Service (repair heating unit)			1999	1,643	110	15	110		201	31
32	Environ Vision Environment(need invoice)			1999	2,919	292	10	292		560	32
33	Chicago Cooling Corp. (shutdown boiler start up & repair A/C)			1999	2,117	212	10	212		335	33
34	ABC Carpentry			1999	2,031	203	10	203		322	34
35	CONTINUE WITH PG 12B . . .										35
36	TOTAL (lines 4 thru 35)				$ 120,305	$ 12,281		$ 12,281	$	$ 32,889	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALDEN HEATHER REHAB & HCC # 0023945 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ABC window screens			1999	3,916	392	10	392		620	9
10	ABC insulation			1999	3,203	320	10	320		507	10
11	Climate Service, Inc. (install condenser)			1999	4,565	304	15	304		457	11
12	Wigdahl Electric(receptacles installed)			1999	5,457	273	20	273		409	12
13	Climate Service, Inc. (replace motor on fan)			1999	2,772	277	10	277		416	13
14	Climate Service, Inc. (replace fan motor)			1999	1,693	169	10	169		254	14
15	Advanced Parts(garbage disposal)			1999	6,515	1,303	5	1,303		1,846	15
16	The Floor Source(install carpet)			1999	2,469	494	5	494		617	16
17	Fox Valley Fire & Safety(door alarm system)			1999	2,540	169	15	169		198	17
18	Climate Service, Inc(boiler)			1999	8,437	422	20	422		457	18
19	ABC (General)			1999	4,053	410	10	410		444	19
20	ABC Roof			1999	2,472	250	10	250		271	20
21	ABC hardware			1999	1,772	179	10	179		194	21
22	Climate Service, Inc(repair burner)			1999	1,615	161	10	161		175	22
23	Fox Valley Fire & Safety(smoke detectors)			1999	7,500	750	10	750		813	23
24	Delete above item(booked below)			2000	(7,500)	(750)	10	(750)		(750)	24
25	ABC-building contstruction/various			2000	3,244	162	10	162		162	25
26	fox valley-smoke detectors			2000	7,500	750	10	750		750	26
27	fox valley-door alarms			2000	1,931	193	10	193		193	27
28	long elev-elevator attachments			2000	1,751	88	20	88		88	28
29	climate services-boiler room			2000	4,422	203	20	203		203	29
30	ci service-drapes/rods			2000	9,460	1,261	5	1,261		1,261	30
31	adjust 1999 total to correct amounts			2000	10	1	10	1		1	31
32	ABC--building maint construct-various			2000	19,015	951	10	951		951	32
33	new horizons-telephone system			2000	1,670	97	10	97		97	33
34	ABC-seal & stripe park. Lot			2000	4,154	69	10	69		69	34
35											35
36	TOTAL (lines 4 thru 35)				$ 104,634	$ 8,900		$ 8,900	$	$ 10,702	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALDEN HEATHER REHAB & HCC # 0023945 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related Party			1978	$ 12,184	$ 554	22	$ 554	$	$ 11,565	4
5	Related Party			1978	5,953	271	32	271		4,767	5
6	(FORUM)										6
7											7
8											8
	Improvement Type**										
9	Related Party - AMS:										9
10	Leasehold Improvement - Remodeling			1993	5,378	223	various	223		115,184	10
11	Leasehold Improvement - Remodeling			1994	2,663	407	various	407		55,299	11
12											12
13	Related Party - Forum:										13
14	Leasehold Improvement - Remodeling			1980	19,102	955	20	955		19,102	14
15	Leasehold Improvement - Remodeling			1980	113		10			113	15
16	Leasehold Improvement - Remodeling			1986	32		6			32	16
17	Leasehold Improvement - Remodeling			1990	51		5			51	17
18	Leasehold Improvement - Remodeling			1991	12		5			12	18
19	Leasehold Improvement - Remodeling			1993	4,085	408	10	408		4,085	19
20	Leasehold Improvement - Remodeling			1993	3,199	330	9.7	330		3,058	20
21	Leasehold Improvement - SIGN			1994	258	21	10	21		145	21
22	Leasehold Improvement - DRYVIT			1994	437	44	12	44		244	22
23	Leasehold Improvement - NEW AC			1995	714	48	10	48		71	23
24	Leasehold Improvement - Roof			1997	961	51	10	51		760	24
25	Leasehold Improvement - Roof			1998	853	57	10	57		369	25
26	Leasehold Improvements-Roof			1985	809	54	19	54		175	26
27	Leasehold Improvements-Roof			1999	1,373	92	15	92		198	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 58,178	$ 3,514		$ 3,514	$	$ 215,231	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALDEN HEATHER REHAB & HCC # 0023945 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 291,017	$ 31,349	$ 31,349	$	VARIES	$ 623,743	37
38	Current Year Purchases	14,096	1,294	1,294		VARIES	1,294	38
39	Fully Depreciated Assets	156,257	1,214	1,214		VARIES	156,315	39
40								40
41	TOTALS	$ 461,369	$ 33,857	$ 33,857	$		$ 781,352	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	VARIOUS	VAN, ENGINES, BUSSES	1998-2000	$ 26,682	$ 2,494	$ 2,494	$	3	$ 3,030	42
43		1998-2000								43
44										44
45										45
46	TOTALS			$ 26,682	$ 2,494	$ 2,494	$		$ 3,030	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 3,661,900	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 70,264	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 153,359	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 83,095	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 3,133,479	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ALDEN HEATHER REHAB & HCC # 0023945 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [x] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		172	10/29/86	$	10	5	3
4	Additions							4
5								5
6								6
7	TOTAL		172		$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease rent elim .

9. Option to Buy: [x] YES [ ] NO Terms: rights of first refusal *

10. Effective dates of current rental agreement:
    Beginning 10/29/86
    Ending 10/31/01

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/01	$ 509,760
13.	12/31/02	$ 509,760
14.	12/31/03	$ 509,760

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO
16. Rental Amount for movable equipment: $ 10,416 Description: copy machine lease
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	various	various	$ 1002	$ 12,021	17
18					18
19					19
20					20
21	TOTAL		$	$ 12,021	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ALDEN HEATHER REHAB & HCC # 0023945 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.
SKILLED NURSING IS ALREADY ON SITE

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ N/A

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number ALDEN HEATHER REHAB & HCC # 0023945 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 18,872	$		$ 18,872	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			18,358			18,358	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			46,549			46,549	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	see page 16A…	# of prescrpts			0	16,283		16,283	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	see page 16A…				0	63,169		63,169	13
14	TOTAL			$		$ 83,779	$ 79,452		$ 163,231	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ALDEN HEATHER REHAB & HCC **#** 0023945 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/00 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 69,182	$	1
2	Cash-Patient Deposits	18,487		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (55,734))	1,132,122		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	114,139		6
7	Other Prepaid Expenses	4,216		7
8	Accounts Receivable (owners or related parties)	1,531,912		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,870,057	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cos	602,625		15
16	Equipment, at Historical Cost	316,933		16
17	Accumulated Depreciation (book methods)	(534,367)		17
18	Deferred Charges	80,863		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 466,054	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,336,111	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,191,833	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	43,234		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	170,928		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,504		31
32	Accrued Real Estate Taxes(Sch.IX-B)	384,457		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(203,859)		35
	Other Current Liabilities(specify):			
36	third party	5,225,007		36
37	accrued expenses/other curr liab-misc	247,817		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,089,922	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,089,922	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,753,811)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,336,111	$	48

***(See instructions.)**

Facility Name & ID Number ALDEN HEATHER REHAB & HCC **#** 0023945 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,284,468)	1
2	Restatements (describe):		2
3	external auditors' adjustments made after 1999 report was		3
4	filed. The adjustments relate to non-allowable costs:		4
5	bad debts and medicare revenue were adjusted.	5,027	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,279,441)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,474,370)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,474,370)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,753,811)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ALDEN HEATHER REHAB & HCC # 0023945 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,333,339	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,333,339	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	(6,222)	6
7	Oxygen	6,830	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 608	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	186	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	28,104	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 28,290	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	35	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 35	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	adjustments to prior year expenses	11,086	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,086	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,373,358	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	969,658	31
32	Health Care	1,410,509	32
33	General Administration	1,244,356	33
	B. Capital Expense		
34	Ownership	955,178	34
	C. Ancillary Expense		
35	Special Cost Centers	173,050	35
36	Provider Participation Fee	94,977	36
	D. Other Expenses (specify):		
37	Note: this will not balance with page 3&4 due to related party		37
38	amounts entered to page 3&4.		38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,847,728	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,474,370)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,474,370)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ALDEN HEATHER REHAB & HCC # 0023945 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,992	2,080	$ 60,874	$ 29.27	1
2	Assistant Director of Nursing	1,349	1,469	32,259	21.96	2
3	Registered Nurses	9,968	11,300	246,942	21.85	3
4	Licensed Practical Nurses	19,274	20,794	346,732	16.67	4
5	Nurse Aides & Orderlies	56,956	61,351	484,477	7.90	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	605	653	13,608	20.84	9
10	Activity Assistants	8,037	8,981	57,174	6.37	10
11	Social Service Workers	1,835	2,109	42,918	20.35	11
12	Dietician					12
13	Food Service Supervisor	1,872	2,080	24,023	11.55	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,554	22,124	158,480	7.16	15
16	Dishwashers					16
17	Maintenance Workers	1,984	2,080	38,068	18.30	17
18	Housekeepers	18,548	19,537	132,824	6.80	18
19	Laundry	8,874	9,722	68,165	7.01	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	3,669	4,270	70,874	16.60	22
23	Office Manager					23
24	Clerical	3,790	4,142	46,220	11.16	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,496	1,687	41,574	24.64	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Cl clin support	1,881	2,089	37,430	17.92	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	162,684	176,468	$ 1,902,642 *	$ 10.78	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	43	2,215	11-3	44
45	Social Service Consultant	14	811	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	57	$ 3,026		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	N/A	$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
d. dalicandro	administrator	0	$ 39,444
f. troha	administrator	0	24,675
m. wartman	administrator	0	19,229
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 83,348

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ALDEN MANAGEMENT	MANAGEMENT FEE	$ 560,520
BLACKMAN KALLICK	ACCOUNTING FEE	11,400
BARRY GREENBURG/HERMANN	LEGAL FEES	3,449
K. FISCH	LEGAL FEES	21,471
KLAFTER/BURK	real estate appraisal-reclassed	31,751
ALDEN DESIGN	DESIGN FEES	1,207
ALDEN BENNETT	CONSTRUCTION MAINT	10,028
US GAS & ENERGY	UTILITY CONSULT	649
Achieve Accred/Gates Mcdonald	JHCACO consult/unempl comp	1,700
KELLY APPRAISAL	real estate appraisal-reclassed	4,500
prior year exp adj	blood glucose-pg 5a adj…	(8,771)
RELATED PARTY-		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 637,904

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 26,704
Unemployment Compensation Insurance	37,564
FICA Taxes	136,362
Employee Health Insurance	35,876
Employee Meals	30,769
Illinois Municipal Retirement Fund (IMRF)*	
UNION,HEALTH, WELFARE	45,689
DENTAL/LIFE INSUR/MISC P/R COSTS	1,844
EMPLOYEE RELATIONS/VACCIN.	3,947
PENSION	17,358
401K MATCHING	415
RELATED PARTY-	37,839
TOTAL (agree to Schedule V, line 22, col.8)	$ 374,367

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	
Health Care Worker Background Check	0
(Indicate # of checks performed 0)	0
IL HEALTH CARE ASSOC.	7,325
Amer.Health Care Ass.	800
Division of Management serv.-subscrip	70
city of harvey/cook county	1,589
related party-	340
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,524

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
GAS/TOLLS/MILAGE-INCIDENTALS	303
Seminar Expense	
HCFA/TRITON	155
IL HEALTH CARE	429
Related party-	8,769
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,656

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ALDEN HEATHER REHAB & HCC # 0023945 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	REPAIR BOILER	1991 *	$ 5,878	5	$	$	$	$	$	$	$	$	$
2	A/C COMPRESSOR/PUM	1992 *	8,561	5-15	962	180	180	180	180	180	180	180	180
3	FAN/MISC HVAC	1993 *	32,328	3-10	4,845	4,097	360	360	360	360	90	1	0
4	PAINTING/HVAC	1995 *	32,616	3-15	8,566	2,914	893	513	513	513	513	513	513
5	PAINTING/HVAC	1996 *	38,397	3-15	9,769	9,769	6,077	1,234	1,066	830	830	830	831
6	REPAIR BOILER	JAN-97	2,242	3	747	747	747	0					
7	REPAIR EXHAUST PIPE	FEB-97	1,583	3	484	528	528	44	0				
8	REPLACE MIXING VAL	MAR-97	1,850	3	514	617	617	103	0				
9	REPAIR HOT WATER T	DEC-97	5,170	3	144	1,723	1,723	1,580	0				
10	REPL HEAT EXCHANGI	OCT-97	2,287	3	191	762	762	572	0				
11	Repair hot water pipes	3/99	3,038	3			844	1,013	1,013	169	0		
12	sump pump repair	8/99	3,450	3			479	1,150	1,150	671	0		
13	painting> $1,500 **	7/99	11,105	3			1,851	3,702	3,702	1,851	0		
14	ABC-construction/maint	6/00	1,907	3				371	636	636	265	0	
15	GT Mechan-water storage	6/00	3,088	3				601	1,029	1,029	430	0	
16	ABC-wall deco/paint.	9/00	13,642	3				1,516	4,547	4,547	3,033	0	
17	painting> $1,500 **	7/00	9,031	3				1,505	3,010	3,010	1,506	0	
18													
19													
20	TOTALS		$ 176,174		$ 26,222	$ 21,337	$ 15,061	$ 14,443	$ 17,207	$ 13,797	$ 6,846	$ 1,524	$ 1,524

Facility Name & ID Number ALDEN HEATHER REHAB & HCC # 0023945 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IHCA $7325**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **12.33**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,074** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **YES**
If YES, give effective date of lease. **10/29/86**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **94,977**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **30,769** Has any meal income been offset against related costs? **NO** Indicate the amount. $ **NA**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **NA**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **NA**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **NA**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ NA

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **Blackman Kallick Bartlestein-in progress** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **no** If no, please explain. **not yet complete**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.